Maryland Pharmacy Program

HEPATITIS C PROTEASE INHIBITORS PRIOR-AUTHORIZATION

Phone: 410-767-1755 or 1-800-492-5231-Option 3 Fax form to: 410-333-5398

Incomplete forms will be returned-A copy of the patient medical history with required lab test results must accompany this request.

Section I. Patient Information

Recipient:_____MA#: _____ Date of Birth:_____/_____/_____
Phone #: (_____)_____-_____ Patient location: ___Home ___Hospital__Clinic__Office
Address: _____

Section II- Drug/Drug Combination is used for an FDA-approved indication

List Hepatitis C triple drug regimen with strengths/dosages:
□ Victrelis: _____ □ Incivek: _____
□ Pegasys: _____ □ PegIntron: _____
□ Ribavirin:_____(Only the generic 200mg ribavirin tab/cap will be approved)
Diagnoses:_____Genotype: □ 1 □ 2 □ 3 □ 4 □ 5 □6
□ Acute Hep C □ Chronic Hep C □ Other_____ Body Weight: _____kg
Baseline HCV RNA level: _____ Date measured:_____
HCV RNA Level at TW 4: _____ Date measured:_____
at TW 8:_____ Date measured: _____
at TW 12:_____ Date measured: _____
at TW 24:_____ Date measured: _____
at TW__: _____ Date measured: _____
Liver enzyme levels: ALT/AST:_____Date measured:_____
Does patient have HIV/HCV co-infection? □ Yes □ No
Has a liver biopsy been performed? □ Yes □ No If yes, date: _____Provide a copy of biopsy results.
Is this for New Therapy? □ New □ Relapser □ Partial responder □ Non-responder
Does the patient have a history of any of the following:
__ Anemia; __ Major uncontrolled depressive illness; __ Alcohol or drug abuse; __Untreated thyroid d/s;
__ Autoimmune hepatitis or other autoimmune conditions; __Pregnant (ribavirin is category X); __Thrombocytopenia;
__Severe concurrent medical d/s (ie. AIDS, cancer, significant CAD;__Decompensated liver d/s;
__Hemoglobinopathies (i.e. sickle cell, thalassemia); __ on didanosine;__ On concomitant interactacting drugs;
___Unstable CVD; __ Solid organ transplant (renal, heart, or lung); Other:_____
Is patient a good candidate for the triple drug regimen in terms of compliance to this complex regimen? □ Yes; □ No
Any prior side-effects/adverse effects from prior therapy, i.e. peg-interferon alfa and/or ribavirin? □ Yes; □ No
List prior failed drug regimens for Hep C and reasons for drug failure:_____
_____
Provide reasons for selecting one Hep C protease inhibitor over the other:_____
_____

Section III- Drug/Drug Combination is used off-label

Off-label indications or off-label dosage:_____
_____
Is drug(s) used as part of a clinical study or trial? □ No □ Yes- If yes, specify sponsoring organization/drug manufacturer:_____
Specify purpose of study: _____
List references and reasons supporting off-label uses:
_____

Note: Off-label indications or off-label dosages may be approved if medically necessary, safe, appropriate, and documented in/supported by one of the three official compendia (AHFS Drug Information, Micromedex Drugdex, and US Pharmacopeia). The Program takes into consideration the Drugdex's ratings related to the strength of recommendation and the evidence on drug safety and efficacy.

I certify that the information provided is accurate. Supporting documentation is available for State audits.

_____, M.D. Prescriber's Name: _____ Date: ____/___ /___
(Prescriber's signature). Tel# (_____) – _____- _____Fax# (_____) - _____ - _____
License #: _____DEA #:_____ Specialty : _____
Address:_____